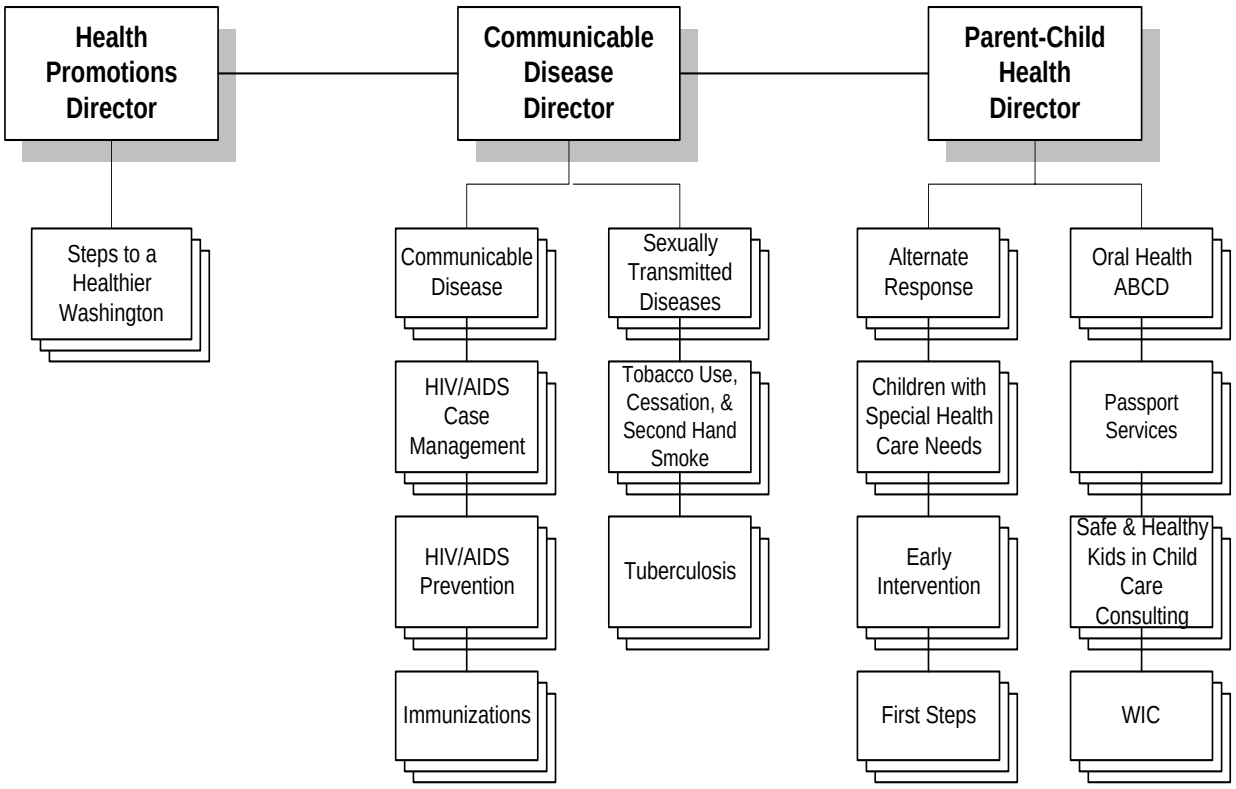
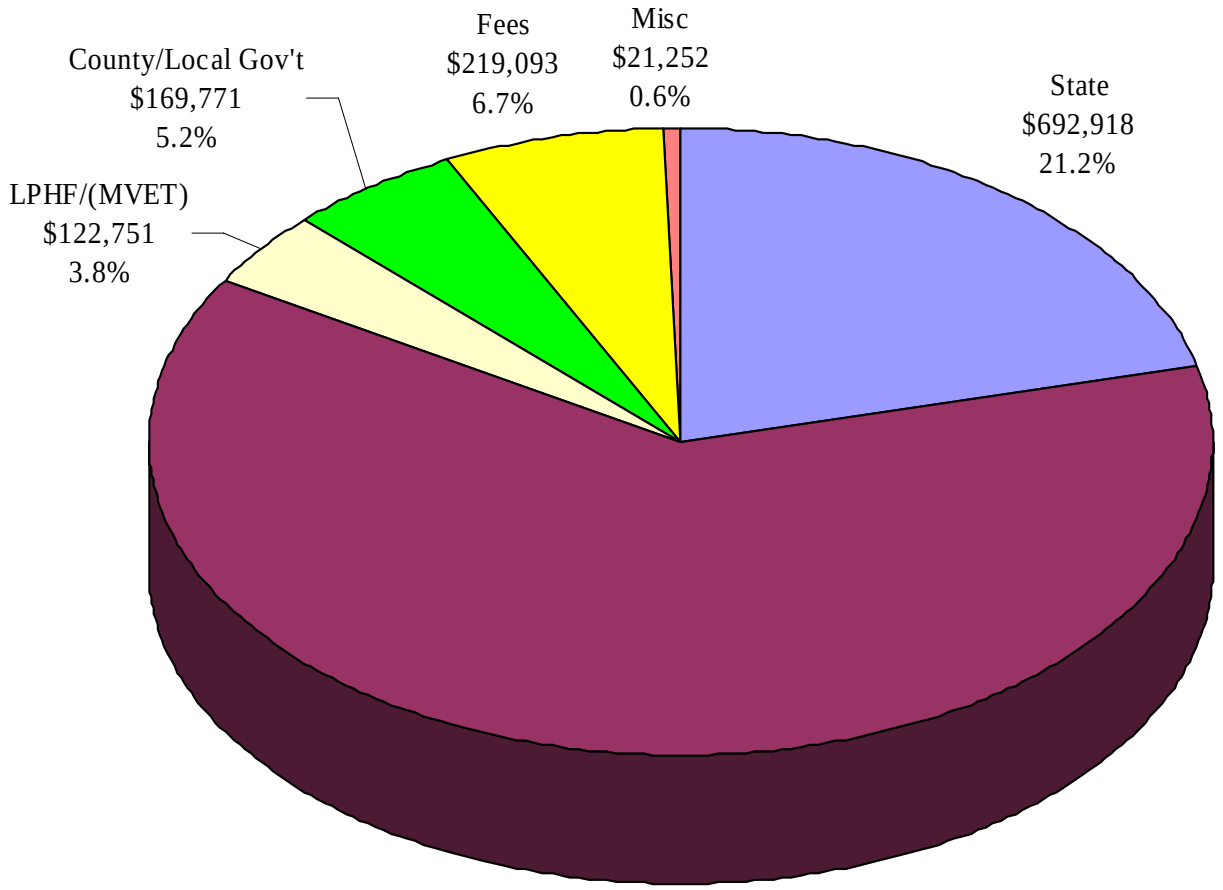
Personal Health Programs



2005 Personal Health Revenue Sources



Total PH Revenue = $3,259,434

PERSONAL HEALTH SECTION

Personal Health is responsive to the health of a person or family in the setting of their surrounding community. Areas of this public health practice focus on communicable disease prevention and treatment, to early intervention programs like WIC and 1st Steps, promoting healthy growth and development. These population based services treat the person and community as a whole, greatly improving the quality of life for all. Disease prevention through vaccines and hand washing are two cornerstone practices still being promoted today to control the spread of disease.

"Always Working for a Safer and Healthier Community"

Outstanding Challenges

Communicable Disease

Pandemic Flu planning uses many already stretched staff resources and having the capacity to respond well when needed will be challenging.

Parent Child Health

Finding funding needed to purchase computer software and hardware to update data collection and charting systems.

2006 Objectives

The Communicable Disease Section will work to increase the number of staff trained to respond to outbreaks and handle communicable disease case reports from three to five.

The Parent Child Health Section will work to increase the percent of staff time spent in direct client services by 50%.

Alternative Response Program

HELPING FAMILIES AT RISK

PROGRAM DESCRIPTION:

The revised code of Washington (RCW 74.14D.020 2) states that Alternative Response System services are voluntary, family-centered services intended to increase the strength and cohesiveness of families that present as at low risk of child abuse or neglect. Based on the CDHD ARS contract, ARS services are authorized for a family in 90 day intervals, the maximum length of service for a family may not exceed 18 months, and a family may only have two service episodes within a three year period. Services are provided by a Public Health Nurse (PHN). The goal of the program is to prevent the re-referral of a family to Child Protective Services (CPS). DSHS is also directed to identify appropriate data to be able to determine and evaluate outcomes from the ARS-delivered services.

DELIVERY MEASURES:

- 58 referrals were received in 2005
- 44 participants engaged in ARS services
- 238 total home visits were made
- 4 clients were referred to ARS services twice during the year
- 7 clients were referred back to CPS due to an increased assessment of risk for child abuse or neglect.

NOTES & Updates:

Referrals are received from a CPS intake worker, and sent to ARS if they are assessed as low to moderate risk. Once referred to ARS, the PHN is expected to have face-to-face contact with clients within 10 working days. If no contact is made, the PHN is required to notify the CPS liaison that the family is unavailable or unwilling to meet. There must be at least two attempts to make a home visit, or to facilitate face to face contact, before a case can be closed. An Exit Summary is provided to CPS indicating the different levels of family participation, and the outcomes achieved when a case is closed.

CHALLENGES:

- The PHN has no control over the referral process, and the size of the two county area can make it difficult to meet the 10 day face-to-face deadline.
- Due to a lack of statewide standardization of services, it is difficult to determine the efficacy of the outcome measures.
- Better data systems are needed. (While data is provided to the DSHS agency, almost no local data is available from them for our program use.

Children with Special Health Care Needs

Program Description:

The Children with Special Health Care Needs (CSHCN) program provides public health nursing services for children (birth to 18 years of age) who have physical, behavioral, or emotional conditions that require health and related services beyond those required by children in general. Children who participate have, or are at risk of developing, a serious or chronic condition including, but not limited to developmental delay (physical or speech), cleft lip and/or palate, cystic fibrosis, metabolic diseases, birth defects (singular or syndromes), cancer, seizure disorders, autism, Down's syndrome, blindness, deafness, or premature birth.

The public health nurse promotes the coordination of systems of care to assure that CSHCN have the opportunity to achieve the healthiest life possible and develop to their fullest potential. The program promotes access to integrated, family centered, culturally competent and community-based programs and services.

Delivery Measures:

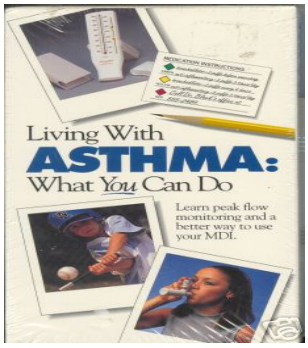
- 143 referrals
- 198 home visits
- 4 Work First evaluations completed

Notes & Updates:

Due to a decrease in staffing, the PHN assessed each of our existing clients and utilized a tiered system for identifying the level of service necessary for each client. We continue to receive the same average number of referrals. Interpreter services are being utilized to meet the needs of the Spanish speaking families.

Challenges:

While currently all data are reported to DOH, the only local data available to us, is in a program specific database that was recently created in 2005.



Communicable Disease / Preventive Health

Program Description:

Epidemiological investigations are conducted for reported communicable diseases. The public health nurse makes an assessment of risk and or exposure of the individual and their contacts. Appropriate preventive measures are taken to stop further transmission through prophylactic treatment and client education. Part of this program is general education for the public through individual contact, the media, and presentations regarding current communicable disease concerns. Completed case reports are sent to the State Epidemiologists.

Delivery Measures:

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- A total of 167 disease reports were investigated.
- 8 clinic sites were visited; the CD reference manual was given to the clinic staff and the State's notifiable disease reporting system was reviewed.
- PSA's were released via e-mail to providers on "Hot Topics" throughout the year.
- Radio interviews and news releases were done during FLU season promoting prevention through vaccination, hand washing, and respiratory etiquette.
- Flu surveillance is conducted during flu season.
- A statewide computer program is up and running (PHIMS) that allows us to share data and outbreak information quickly with the Department of Health.

Notes & Updates: **2005 COMMUNICABLE DISEASE CASE REPORTS**

CAMPYLOBACTER	10	CHLAMYDIA	216	E COLI OH157	1
FOODBORN OUTBREAKS	2	GIARDIA	4	GONORRHEA	5
HEPATITIS A	2	HEPATITIS B	1	HEPATITIS C	33
GENITAL HERPES	41	HUS	1	PERTUSSIS	2
SALMONELLA	8	SHIGELLA	5	SYPHILIS	2
TURBERCULOSIS	2				

Challenges:

Pandemic flu worries, staff capacity to be able to respond to emerging threats and being able to recognize emerging infectious diseases will be a continual challenge. The threats of bio-terrorism also continue to impact our local health capacity and delivery system.

COVER YOUR COUGH, WASH YOUR HANDS & STAY HOME IF YOU ARE ILL

Early Intervention Program

Program Description:

This program provides an initial public health assessment and on-going Public Health Nurse case management services for approximately ten to sixteen families. Case management and direct services include teaching families about safety, appropriate growth and development, expectations during family visits, how to access medical care, development of service plans, developmental testing, information and referral, and other public health services. Services can be provided for 90 days to 18 months, depending on the needs of the client or family. The program's purpose is preventative in nature by referring to services that enable proactive approaches to health maintenance. This program is funded by a contract with the Department of Social and Health Services.

Delivery Measures:

- 51 families served
- 94 children impacted
- 160 home visits

Notes & Updates:

Staff received annual training in the field of child abuse and neglect through the Children's Justice Conference in Seattle and the Scan Conference in Spokane. Staff participated weekly as a member of the child protective service team, reviewing cases of children removed from the home for abuse or neglect. An excellent working relationship has developed with the child protective team and community support services.

A few cases have required more frequent visits and interventions. Identifying a family's continued intervention needs and having the flexibility to continue to work with the family is a big plus of this program.

HELPING FAMILIES

Maximizing a Child's Potential

First Steps

Program Description:

Public health nurses, behavioral health specialists and a nutritionist provide support, education and case management linkages, referral and advocacy for Medicaid eligible pregnant and parenting women through home or office visits.

Delivery Measures:

- 793 referrals received for the First Steps program
- 1,430 home or office visits provided by staff
- 388 referrals for High Risk Newborns were received from Central Washington Hospital
- 127 of the newborn referrals were seen by a staff member
- 198 of the newborn referrals had telephone contact with a staff member
- 59 children were screened for Child Find in clinics located in Bridgeport and Waterville

Notes & Updates:

- DOH and DSHS continue to redesign the First Steps program. New paper forms for documentation were implemented at the end of 2005.
- The Public Health Nursing Directors are working with DOH and DSHS to standardize the services provided by MCH staff and to help define the program performance measures.
- The CDHD program improvement process has resulted in several system changes to help support the MCH professional staff. A community health worker has been hired and clerical support is now accessible to the MCH program staff.

Challenges:

Lack of a client tracking system and paper forms make it difficult to describe and report the population that CDHD MCH programs serve. Staff has developed program specific databases and spreadsheets to help with this issue. CDHD staff will continue to explore electronic records as a method to improve documentation and the reporting of outcome measures.

HIV/AIDS Case Management

Program Description:

HIV/AIDS is a devastating disease that is communicable to others through unsafe sexual practices and injectible drug use. Case management services are provided to residents of Chelan-Douglas Counties who are HIV positive or AIDS diagnosed. These services include assessment, education about the disease and risk reduction behaviors, care planning, referrals for medical care, medications, housing, dental care, crisis intervention, and disease tracking. The case manager facilitates access to emergency assistance for food and transportation, and the Early Intervention Insurance program.

Delivery Measures:

- 22 Clients received case management services
- 96 Office contacts
- 800 collateral contacts for clients
- Attended doctor's visit with clients
- Home visits to assess client needs

Notes & Updates:

We served 22 clients between the ages of 15 and 72 with coordination of services between the clients and DSHS, LINK bus, local pharmacies, charitable organizations, medical facilities, physicians, and laboratories.

There are many more people living in our community with AIDS or HIV that do not need or wish to receive case management services at this time.

Challenges:

Funding for HIV/AIDS activities continues to be reduced each year threatening the level of services we provide for clients. The increase in the number of our clients receiving medical coupons has helped delay reductions in program services. Another challenge is teaching clients how to become their own advocates.

Prevent the spread of HIV

HIV/AIDS Prevention Program

Program Description:

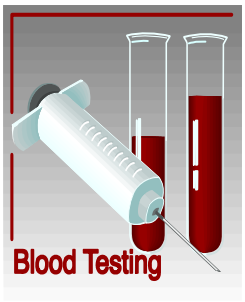
General Education Programs are classroom presentations which are held to meet the blood borne pathogen training requirements for adults seeking professional licensing or other types of certification for a daycare license, for example, from the State of Washington. We help the community to meet compliance issues and regulations as they apply to blood borne pathogen safety. **High Risk Outreach** provides HIV/AIDS information to mono-lingual Spanish speaking residents as well as injection drug users. A vital role is seeking out individuals at greatest behavioral risks of contracting HIV and providing one-to-one counseling, risk reduction information, and referrals to HIV testing sites. This type of outreach includes parks, streets, hangouts, bars, orchard camps, and campsites. Agency sites for this program include The Center for Drug and Alcohol Treatment, The Salvation Army, and The Friendship Center.

Delivery Measures:

- A total of 92 General Education presentations were conducted for 865 individuals.
- The Outreach Program contacted a total of 952 individuals..
- Standardized High Risk programs for targeted individuals were developed by our staff and are now in use on laptops for HIV outreach activities.
- We work in partnership with Columbia Valley Medical Center and Canyon View Group Home and Wenatchee Valley College to reach high risk individuals.

Notes & Updates:

Early diagnosis through testing allows those with HIV to:



1. Increase their life expectancy with early and consistent treatment.
2. Have an opportunity for partner notification for those in risk contact with the person that tested HIV+.
3. To reduce further infection in others by properly counseling and training those infected to stop all risky contact with those who are still uninfected.

Challenges:

Hiring a new liaison to specifically target high-risk populations in our communities has been difficult as people are reluctant to work publicly in these high risk groups. It is a goal to hire a liaison as soon as possible, as this added to the successes of 2005.

Immunizations

Program Description:

Immunizations reduce the incidence of preventable diseases, the death and morbidity from preventable diseases and save money by reducing the need for hospitalizations due to preventable disease. Infant, childhood, college, adult and overseas travel immunizations are available at reduced costs for Chelan and Douglas county residents. Informational materials regarding vaccines are distributed to the community and all vaccine providers. Educational updates are provided on site for immunization providers and their staff. Low cost and sliding fee scale services are available to low income clients. Public education regarding preventable disease prevention is distributed via the media to the community. Audits for compliance to the childhood immunization schedule for two year old children are done annually at selected provider sites.

Delivery Measures:

- Rural outreach clinics served eleven cities with 73 clinics
- Tuesday evening clinic hours are available for working clients
- A flu clinic for seniors at the Wenatchee Senior Center served 431 people.
- Three immunization newsletters were sent to all vaccine providers.
- Six educational updates were given to private providers.
- Provided 21 corporate flu clinics.
- Provided 7 assisted living flu clinics.
- 2,762 Clients were given 2,951 doses of vaccine at rural outreach clinics
- 337 Fifth graders received MMR #2 at 20 school site clinics
- 4,245 Clients received flu vaccine.
- 7,978 Doses of vaccine were given by CDHD.
- 154 Clients were seen in the after hours clinic on Tuesday between 5 and 6 pm
- 40,072 Doses of vaccine were distributed to the private providers.
- 1,500 Bibs with immunization schedules were distributed to newborns at birth.
- Four vaccine provider sites had AFIX immunization assessment visits.
- Three provider sites had regular quality assurance and AFIX / VFC site visits.
- Benchmarking activities were completed in all immunization practices in September

Notes & Updates:

- Our immunization rates are among the best in the State for children.
- This was the last year for 5th grade MMR to be offered in the school setting.

Challenges:

- Maintaining high immunization rates in our community for 2 year-old children.
- Maintaining staffing levels to offer immunization services five days a week.

Oral Health

Program Description:

The oral health information and preventive services program is designed to reduce the need for restorative oral health services in specifically targeted high-risk populations and the community in general. A public health dental hygienist provides screenings and other assessment activities, preventive education, preventive service and oral health counseling. CDHD promotes the use of preventive oral health strategies and facilitates school-based preventive dental programs.

Delivery Measures:

- 306 children received dental screenings at Head Start/ECEAP
- 256 of the children received fluoride varnish treatments
- 38 developmentally disabled clients received dental screenings
- 26 staff case workers for the developmentally disabled clients received oral health education
- 3,335 children and 90 adult/parents attended oral health education presentations
- 52 healthcare and allied healthcare staff attended oral health presentations.
- 1187 children were enrolled in the Access to Baby and Child Dentistry (ABCD) program.

Notes & Updates:

- Staff assisted the State of Washington in conducting the Smile Survey and conducted a local survey for comparison to the state survey.
- CDHD no longer provides oral health services for Okanogan County. The Okanogan County contract was terminated on 1/1/05.
- The Chelan-Douglas Oral Health Coalition is expanding and will be exploring issues of access to oral health care in our community.
- Staff is exploring the possibility of extending the fluoride varnish program to other early learning programs in the two county area.

Challenges:

Education of our community and early access to dental care continue to be the focal points for our oral health program.

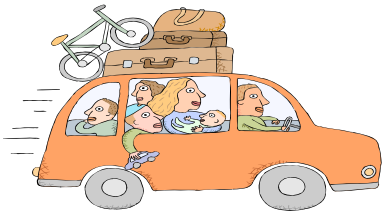
Passport Program

Program Description:

The Foster Care Passport Program is an electronic tracking system for the health and educational records of children who are placed in out-of-home care for more than 90 days. The Department of Social and Health Services (DSHS) and Chelan-Douglas Health District (CDHD) collaborate in the administration of this program. The Public Health Nurse (PHN) resides in the Children's Administration offices at DSHS. The information she collects from the known medical providers about the child's medical history and treatment is put into an electronic tracking system. A packet is produced containing the important information about the child for the foster parents or relative caregivers. It is given to them at the time of the child's placement. The information is updated yearly, and when a child moves to a new home and is also available to the Department of Child and Family Services (DCFS) social workers.

Delivery Measures:

- 67 Passports were produced for children placed in care in 2005



Notes & Updates:

The Passport Program is intended to provide a clear, concise, and current picture of the child's medical status.

Challenges:

- Obtaining medical records can sometimes require multiple medical releases and court orders. At times, the consents expire before the records are released necessitating a second request for records.

Safe and Healthy Kids
Child Care Consulting

CHILD CARE IN WASHINGTON STATE

Program Description:

Research suggests that the more education a child care provider has on child care topics, including basic health issues, the better quality of care children in their care receive. Children are particularly susceptible to illnesses due to immature immune systems and to injuries due to their lack of judgment. A public health nurse child care consultant provides licensed homes and centers with information about public health issues, safety and child development. This position requires knowledge of licensing regulations regarding health and safety procedures, institutional management and the relationship between parent, child and child care provider. We can assist the provider, upon their request, in foreseeing situations of risk and work with them toward minimizing the problems identified. Prevention services include the importance of immunization record checking, consulting on health policies, advice on what is “safe” play equipment, and advice for providers and parents on how to care for special needs children in child care, especially the medically or developmentally delayed.

Delivery Measures:

- 87 Scheduled Infant Care Consulting visits to Centers with an infant room.
- Telephone consultations and follow up with relevant materials.
- Referrals to community resources
- 4 Community-wide trainings.
- DSHS orientations held for potential child care providers promoting child care services.
- 23 Health related Independent Learning Modules were distributed to child care providers.

Notes & Updates:

Healthy Child Care Washington (HCCW) utilizes a web-based reporting system (http://www3.doh.wa.gov/hccwdc). This reporting system documents system development activities, child care providers’ awareness and behaviors, number and type of parent and providers’ communications and child care policies and environments that improve the health and safety of children in child care. The data provided on the impacts of these strategies support partners in their efforts to continuously improve child health and safety.

The PHN tracked information on every contact with providers and entered this data into the website. Currently, only statewide data is available from this site, however local data should be available in the near future.

Challenges:

The capacity to offer classes to Spanish speaking providers, who now represent 55% of licensed Home providers.

Sexually Transmitted Diseases

Program Description:

Through education and treatment, the incidence and transmission of sexually transmitted diseases like chlamydia, gonorrhea, herpes, and HIV will be decreased or prevented. The consequences of acquiring these diseases can be quite serious. Complications include sterility, fetal and infant morbidity and mortality, long term medical interventions, and death. We provide diagnosis and treatment of sexually transmitted diseases and HIV counseling and testing services. We conduct epidemiological investigations and follow-up on reported cases and all case reports are sent on to the State. This program offers consultation for medical providers and partner notification and follow up for their case reports. We provide resources and general health education to the public.

Delivery Measures:

- Clients have access to diagnosis and treatment services for STD's and access to HIV counseling and testing.
- Follow-up on case reports verifies treatment of the client and all their contacts.
- Epidemiological investigations are conducted as indicated, through mail or telephone contact and when necessary home visits.
- Presentations have been provided to the Wenatchee Valley College, the Juvenile Center and Canyon View Group Home.
- 129 individuals were served in the STD clinic.
- 249 individuals received counseling and testing for HIV infection within the Health District office and the Center for Alcohol and Substance Abuse.
- The AIDS case manager provides presentations quarterly on the Junior college campus.

Notes & Updates:

Chelan Douglas Health District continues to be represented on the Board of Family Planning.

2005 STD Case Reports

216 Chlamydia, 5 Gonorrhea, 41 Genital Herpes,& 2 Syphilis Cases

Challenges:

Continuing STD presentations for high risk people and the college community is difficult with our limited funding and available staff time.

The Steps Project's purpose is to prevent or reduce the complications of asthma, diabetes, and obesity through initiatives that improve nutrition, increase physical activity and prevent tobacco use. The projects stated mission, vision and values are:

- **Vision:** A partnership for healthier living in North Central Washington
- **Mission:** Promote the knowledge, resources, opportunity, and motivation to achieve a healthier lifestyle
- **Value:** Equality of access

Executive Summary

In 2005 the Steps Project efforts included these highlights:

- **Community:** Conducted Diabetes Risk Assessment- 750+ Completed, produced and launched a Diabetes Media Campaign in partnership with Department of Health.
- **Health Care:** Distributed BMI Resource materials in 3 counties, and implemented a non-gym based Diabetes Challenge mode.
- **School:** Conducted School Health Index in 8 Schools/School Districts. Provided curriculum and technical assistance to support them in meeting legislative mandates.
- **Worksite:** Developed and launched "Healthiest Business Challenge" - 19 businesses with 2531 employees. Created and distributed a Tobacco-free workplace brochure in partnership with the Environmental Health and Tobacco programs- 480 recipients.
- **Project wide:** Launched NCWSteps.org website and recruited 4 additional partners to join the Steps Leadership Team.

Outstanding Challenges

In 2006 and beyond an ongoing effort will be made to overcome these challenges:

- Establish and maintain partnerships with a broad range of community organizations.
- Implement strategies that meet the standards and requirements of both the public and private partners.
- Maintain the intent and focus of the projects sustainability by implementing policy and built environment initiatives.

2006 Objectives

In 2006 the Steps Project will collaborate with new and existing partners to:

- Implement the Take Action Expo and offer community education programs that address asthma, diabetes, obesity, and tobacco prevention.
- Implement gym, and non-gym based Diabetes Challenge's in both Spanish and English. Collaborate to implement a Shared Care model.
- Implement school policy changes that meet legislative intent and improve nutrition, increase physical activity, and reduce asthma triggers.
- Implement the Healthiest Business Challenge and create a worksite wellness manual to assist businesses in program development and policy change.

Tobacco Prevention and Control

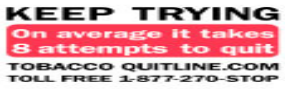
Program Description:

Second hand smoke annually kills an estimated 38,000 non smokers. CDC has determined there is a significant risk from tobacco smoke for high risk groups which include pregnant women, children, the elderly and those suffering from respiratory diseases. Tobacco smoke also poses increases in health risks for the general community at large. This public health program works with community partners to increase tobacco cessation rates and decrease second hand smoke by promoting clean indoor air.

Delivery Measures:

- Co-facilitated the monthly Tobacco Coalition Meetings and helped with the coalition sponsored event hosting Gov. Christine Gregoire.
- Presented the tobacco cessation program to more then 100 local healthcare staff.
- Presented the tobacco program information to the CDHD Board members.
- Participated on Work Site and Healthcare committees through the STEPS program.
- Provided educational resources regarding the dangers of second hand smoke to all area First Steps and WIC clients.
- Worked with the CDHD Environmental Health Director and DOH in providing information for community members regarding I-901.
- Promoted DOH sponsored program for young adults for cessation resources at community and healthcare provider meetings.
- Provided Basic Tobacco Intervention Skills (BTIS) training to 13 healthcare professionals.
- Provided Quit Line and informational resources to clinic sites at Wenatchee Valley Medical Center and Central Washington Hospital.

Notes:



U.S. tobacco use = health care costs & missed work = a cost of $150,000 billion

Secondhand smoke has higher levels of toxins when it exists in small spaces like the home or car.

Successful community partnerships help promote sustainable activities through policy development and education. I-901 greatly enhanced our ability to reach more people.

Challenges:

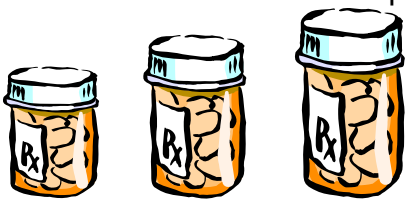
It will be important to continue partnership development with our community members, the STEPS program, Together for a Drug Free Youth, the Tobacco coalition and health care partners in the interest of health as funding will cease in two years for this program.

Tuberculosis Prevention and Control

Program Description:

Treatment of latent TB infection reduces the number of people in the pool of infected individuals and dramatically reduces the numbers of future illnesses. Maintaining individuals on preventive therapy for latent TB infection and providing complete treatment to patients with active tuberculosis is necessary to prevent the spread of TB or Multi-drug Resistant Tuberculosis (MDR) in our community. TB testing is offered for employment, drug & alcohol evaluations, adult or child care placement homes or contacts of active cases to prevent transmission in these settings. CDHD provides treatment for people diagnosed with active tuberculosis and prophylactic treatment to their close contacts. This program provides education to medical providers, clients and community regarding TB questions. Early identification and treatment of infectious cases is our program goal.

Delivery Measures:



- We provided services for 2,761 client visits in 2005.
- Most clients receive therapy in the clinic setting.
- Home visits are made when it is necessary to use directly observe therapy to assure compliance.
- Chest x-ray services are contracted through Wenatchee Valley Clinic.
- Bimonthly clinics are staffed by contracted MD's to read x-rays and prescribe treatment for individuals exposed to tuberculosis or with active disease.
- Positive individuals are case managed. Case management of individuals with active communicable diseases assures compliance with treatment and follow up.
- TB educational updates are offered to nursing home staff and other agencies.
- Collaborative efforts with The Drug and Alcohol Center and Columbia Valley Community Health Services assists in providing follow-up to high-risk individuals in our community in need of TB services.

Notes & Updates:

We remain a low incidence TB community for active disease. We appreciate the funding provided by the Board of Health. This allows us to continue to be able to provide the successful prevention efforts funded by our TB assessment dollars.

Challenges:

Continued vigilance is needed, especially with the threat of multiple drug resistant TB and the State TB outbreaks.

Women, Infants and Children (WIC)

Program Description:

WIC is a nutrition program that helps pregnant women, new mothers, and young children eat well, learn about nutrition and stay healthy. Sixty-seven percent of all infants born in our counties receive WIC services. Services are provided to medically or nutritionally at-risk low-income pregnant women, breast feeding postpartum women, infants, and children to age five years. WIC clients receive supplemental food vouchers, nutritional education, counseling and referrals for on-going health care needs. Seventy one percent of the households receiving WIC have at least one working family member and earn incomes below or at the federal poverty level.

Delivery Measures:

- 720 clients – state authorized caseload
- 810 clients - average clients on caseload to meet WIC participation standards
- 343 client contacts - monthly average
- 4,116 client contacts in 2005
- CDHD WIC supplies about 165,000 gallons of milk, 45,300 boxes of cereal and 68,900 cartons of eggs to families in our two counties
- About $450,000 enters our local economy through CDHD WIC
- CDHD served approximately 1300 unduplicated individuals in WIC.
- CDHD serves about 26% of the total WIC population

Notes & Updates:

- Staff maintained 100% of the state authorized caseload of 720.
- The state WIC expectation is to serve 98-103% on a monthly basis.
- CDHD received one time funding, in the amount of $1,378 for WIC nutrition educational materials and staff training in 2005.
- Our annual reimbursement rate per client is $112
- Staff is continuing to evaluate this program for quality improvements

Challenges:

Maintaining delivery of WIC services to the state authorized caseload.